FOR OHF USE

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0022418

Facility Name: REGENCY HEALTHCARE & REHABILITATION CENTRE, INC.

Address: 6631 N MILWAUKEE (Number) NILES (City) 60714 (Zip Code)

County: COOK

Telephone Number: (847) 647-7444 **Fax #** (847) 588-1330

IDPA ID Number: 36-2871301-001

Date of Initial License for Current Owners: 05/01/76

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve N. Lavenda **Telephone Number:** (847) 236-1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) Benjamin Rogow

(Title) Vice President

Paid Preparer

(Signed) SEE ACCOUNTANT'S REPORT ATTACHED (Date)

(Print Name and Title) Cary C. Buxbaum

(Firm Name & Address) FROST, RUTTENBERG & ROTHBLATT, P.C.
111 Pfingsten Rd. , Suite 300, Deerfield, Il 60015

(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number REGENCY HEALTHCARE & REHABILITATION CENTRE, INC. # 0022418 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	300	Skilled (SNF)	300	109,800	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	300	TOTALS	300	109,800	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	10,388	4,303	6,499	21,190	8
9	SNF/PED					9
10	ICF	37,512	29,390		66,902	10
11	ICF/DD					11
12	SC	748			748	12
13	DD 16 OR LESS					13
14	TOTALS	48,648	33,693	6,499	88,840	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.91%

D. How many bed-hold days during this year were paid by Public Aid?
NONE (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NA

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 04/30/81

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 04/30/81 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified _____ and days of care provided 5,753

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number REGENCY HEALTHCARE & REHABILIT # 0022418 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	371,221	45,612	18,078	434,911		434,911		434,911			1
2	Food Purchase		385,022		385,022	(46,116)	338,906	(1,451)	337,455			2
3	Housekeeping	292,203	37,419		329,622		329,622		329,622			3
4	Laundry	98,906	24,194	3,050	126,150		126,150		126,150			4
5	Heat and Other Utilities			166,526	166,526		166,526	2,350	168,876			5
6	Maintenance	82,036	24,641	77,403	184,080		184,080	(3,117)	180,963			6
7	Other (specify):*											7
8	**TOTAL General Services**	844,366	516,888	265,057	1,626,311	(46,116)	1,580,195	(2,218)	1,577,977			8
	B. Health Care and Programs											
9	Medical Director			15,000	15,000		15,000		15,000			9
10	Nursing and Medical Records	2,941,802	99,954	159,668	3,201,424		3,201,424		3,201,424			10
10a	Therapy	85,494	800	2,861	89,155		89,155		89,155			10a
11	Activities	159,796	11,224	1,680	172,700		172,700		172,700			11
12	Social Services	104,916		4,800	109,716		109,716		109,716			12
13	Nurse Aide Training											13
14	Program Transportation			120	120		120	338	458			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,292,008	111,978	184,129	3,588,115		3,588,115	338	3,588,453			16
	C. General Administration											
17	Administrative	166,416		472,491	638,907		638,907	(132,873)	506,034			17
18	Directors Fees											18
19	Professional Services			100,536	100,536	(5,244)	95,292	257	95,549			19
20	Dues, Fees, Subscriptions & Promotions			178,360	178,360		178,360	(120,062)	58,298			20
21	Clerical & General Office Expenses	286,896	60,952	122,988	470,836		470,836	(101,970)	368,866			21
22	Employee Benefits & Payroll Taxes			875,164	875,164	46,116	921,280		921,280			22
23	Inservice Training & Education											23
24	Travel and Seminar			5,825	5,825		5,825	32	5,857			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			82,999	82,999		82,999	8,615	91,614			26
27	Other (specify):*							15,185	15,185			27
28	**TOTAL General Administration**	453,312	60,952	1,838,363	2,352,627	40,872	2,393,499	(330,816)	2,062,683			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,589,686	689,818	2,287,549	7,567,053	(5,244)	7,561,809	(332,697)	7,229,112			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

REGENCY HEALTHCARE & REHABILITATION CENTRE, INC.
0022418
COST REPORT RECLASSIFICATIONS
01/01/00
12/31/00

SCHEDULE V LINE #			
22	EMPLOYEE BENEFITS	46,116	
2	FOOD		46,116

To reclass cost of employee meals from raw food to employee benefits

33	REAL ESTATE TAX	5,244	
19	PROFESSIONAL FEES		5,244

To reclass cost of appealing real estate taxes

Facility Name & ID Number REGENCY HEALTHCARE & REHABILITATION CENTE #0022418 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			119,596	119,596		119,596	193,740	313,336			30
31	Amortization of Pre-Op. & Org.			10,704	10,704		10,704	(10,704)				31
32	Interest			193,332	193,332		193,332	415,098	608,430			32
33	Real Estate Taxes			386,543	386,543	5,244	391,787	9,449	401,236			33
34	Rent-Facility & Grounds			1,052,400	1,052,400		1,052,400	(1,052,400)				34
35	Rent-Equipment & Vehicles			18,337	18,337		18,337		18,337			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,780,912	1,780,912	5,244	1,786,156	(444,817)	1,341,339			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	71,609	220,696	99,719	392,024		392,024	872	392,896			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			164,700	164,700		164,700		164,700			42
43	Other (specify):*	40,357			40,357		40,357	(40,357)				43
44	**TOTAL Special Cost Centers**	111,966	220,696	264,419	597,081		597,081	(39,485)	557,596			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,701,652	910,514	4,332,880	9,945,046		9,945,046	(816,999)	9,128,047			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number REGENCY HEALTHCARE & REHABILITATION CEI # 0022418 Report Period Beginning: 01/01/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	56,859	30		9
10	Interest and Other Investment Income	(64,834)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,451)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(77,717)	21		24
25	Fund Raising, Advertising and Promotional	(64,062)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(21,601)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(55,917)	20		28
29	Other-Attach Schedule	(97,185)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (325,908)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(491,090)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (491,090)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (816,999)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

REGENCY HEALTHCARE & REHABILITATION CENTRE, INC.

ID# 0022418

Report Period Beginning: 01/01/00

Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Deferred Maintenance	$	6	1
2	Non Allow Related Party Interest	(17,768)	32	2
3	Charitable Contributions	(200)	20	3
4	Misc Income	(156)	21	4
5	Promotional Salary	(40,357)	43	5
6	Depreciation Non-Care Asset	(6,206)	30	6
7	Political Contribution -(COPE)	(517)	20	7
8	Regency At Home Care -Interest Expense	(6,562)	32	8
9	Amort. Of Loan Acquisition Cost	(10,704)	31	9
10	Bank Charges	(3,028)	21	10
11	Collection Service	(5,077)	19	11
12	Prior Year Legal Fees	(330)	19	12
13	Capitalized R&M	(6,280)	6	13
14				14
15				15
16				16
17				17
18				18
19				19
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87				87
88				88
89				89
90	**Total**	(97,185)		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number REGENCY HEALTHCARE & REHABILITATION CENT # 0022418 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary													1
2	Food Purchase	(1,451)											(1,451)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			1,159		1,191							2,350	5
6	Maintenance	(6,280)		1,073		2,090							(3,117)	6
7	Other (specify):*													7
8	**TOTAL General Services**	(7,731)		2,232		3,281							(2,218)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records													10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation					338							338	14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**					338							338	16
	C. General Administration													
17	Administrative				(132,873)								(132,873)	17
18	Directors Fees													18
19	Professional Services	(5,407)		176	3,341	2,147							257	19
20	Fees, Subscriptions & Promotions	(120,696)		33	44	557							(120,062)	20
21	Clerical & General Office Expenses	(102,502)		72	252	208							(101,970)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar					32							32	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice			330		8,285							8,615	26
27	Other (specify):*				15,185								15,185	27
28	**TOTAL General Administration**	(228,605)		611	(114,051)	11,229							(330,816)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(236,336)		2,843	(114,051)	14,848							(332,697)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number REGENCY HEALTHCARE & REHABILITATION CENT # 0022418 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	50,653	134,359	4,170		4,558							193,740	30
31	Amortization of Pre-Op. & Org.	(10,704)											(10,704)	31
32	Interest	(89,164)	481,595	4,899		17,768							415,098	32
33	Real Estate Taxes			4,660		4,789							9,449	33
34	Rent-Facility & Grounds		(1,032,000)	(20,400)									(1,052,400)	34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*													36
37	**TOTAL Ownership**	(49,215)	(416,046)	(6,671)		27,115							(444,817)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers					872							872	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(40,357)											(40,357)	43
44	**TOTAL Special Cost Centers**	(40,357)				872							(39,485)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(325,908)	(416,046)	(3,828)	(114,051)	42,835							(816,999)	45

Facility Name & ID Number REGENCY HEALTHCARE & REHABILITATION CENTRE, INC. # 0022418 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
KENNETH NIEMAN	33.34%	NONE		REGENCY MGMT	NILES	MGMT. CO.
BENJAMIN ROGOW	33.33%	NONE		KNR ENTERPRISE	NILES	BUILDING CO.
LOTHAR KAHN	33.33%	NONE		REGENCY REHAB	NILES	THERAPY CO.
				REGENCY BUILDIN	NILES	BUILDING CO.

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 1,032,000	Regency Building	100.00%	$	$ (1,032,000)	1
2	V	30	Depreciation		Regency Building	100.00%	134,359	134,359	2
3	V	32	Interest		Regency Building	100.00%	481,595	481,595	3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,032,000			$ 615,954	$ * (416,046)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number REGENCY HEALTHCARE & REHABILITATION CENTRE, INC. # 0022418 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	KNR ENTERPRISES	100.00%	$ 1,159	$ 1,159	15
16	V	6	REPAIRS AND MAINT.		KNR ENTERPRISES		1,073	1,073	16
17	V	19	PROFESSIONAL FEES		KNR ENTERPRISES		176	176	17
18	V	20	DUES AND SUBS.		KNR ENTERPRISES		33	33	18
19	V	21	CLERICAL		KNR ENTERPRISES		72	72	19
20	V	26	INSURANCE		KNR ENTERPRISES		330	330	20
21	V	30	DEPRECIATION		KNR ENTERPRISES		3,290	3,290	21
22	V	32	INTEREST EXPENSE		KNR ENTERPRISES		4,899	4,899	22
23	V	33	REAL ESTATE TAXES		KNR ENTERPRISES		4,660	4,660	23
24	V	33	R. ESTATE TAX-PROTEST FEES		KNR ENTERPRISES				24
25	V								25
26	V	34	RENT	20,400	KNR ENTERPRISES			(20,400)	26
27	V								27
28	V								28
29	V	30	DEPRECIATION		KNR ENTERPRISES		880	880	29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 20,400			$ 16,572	$ * (3,828)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number REGENCY HEALTHCARE & REHABILITATION CENTRE, INC. # 0022418 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	PROFESSIONAL FEES	$	REGENCY MANAGEMENT CORP.	100.00%	$ 3,341	$ 3,341	15
16	V	20	DUES, SUBSCRIPTIONS		REGENCY MANAGEMENT CORP.		44	44	16
17	V	21	CLERICAL AND GENERAL		REGECY MANAGEMENT CORP.		252	252	17
18	V								18
19	V	17	MANAGEMENT FEES	472,492	REGENCY MANAGEMENT CORP.			(472,492)	19
20	V								20
21	V								21
22	V	17	ADMINISTRATIVE		REGENCY MANAGEMENT CORP.		125,333	125,333	22
23	V	27	EMPLOYEE BENEFITS		REGENCY MANAGEMENT CORP.		5,604	5,604	23
24	V								24
25	V	17	ADMINISTRATIVE		REGENCY MANAGEMENT CORP.		114,286	114,286	25
26	V	27	EMPLOYEE BENEFITS		REGENCY MANAGEMENT CORP.		5,110	5,110	26
27	V								27
28	V	17	ADMINISTRATIVE		REGENCY MANAGEMENT CORP.		100,000	100,000	28
29	V	27	EMPLOYEE BENEFITS		REGENCY MANAGEMENT CORP.		4,471	4,471	29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 472,492			$ 358,441	$ * (114,051)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number REGENCY HEALTHCARE & REHABILITATION CENTRE, INC. # 0022418 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	REGENCY REHABILITATION SERVICES, INC.	100.00%	$ 1,191	$ 1,191	15
16	V	6	REPAIRS AND MAINT.		REGENCY REHABILITATION SERVICES, INC.		2,090	2,090	16
17	V	10-a	THERAPY CONSULTANTS		REGENCY REHABILITATION SERVICES, INC.		1,275	1,275	17
18	V	14	PROGRAM TRANSPORTATION		REGENCY REHABILITATION SERVICES, INC.		338	338	18
19	V	19	PROFESSIONAL FEES		REGENCY REHABILITATION SERVICES, INC.		2,147	2,147	19
20	V	20	DUES AND SUBS.		REGENCY REHABILITATION SERVICES, INC.		557	557	20
21	V	21	CLERICAL		REGENCY REHABILITATION SERVICES, INC.		208	208	21
22	V	24	SEMINARS & EDUCATION		REGENCY REHABILITATION SERVICES, INC.		32	32	22
23	V	26	INSURANCE		REGENCY REHABILITATION SERVICES, INC.		8,285	8,285	23
24	V	30	DEPRECIATION		REGENCY REHABILITATION SERVICES, INC.		4,558	4,558	24
25	V	32	INTEREST EXPENSE		REGENCY REHABILITATION SERVICES, INC.		17,768	17,768	25
26	V	33	REAL ESTATE TAXES		REGENCY REHABILITATION SERVICES, INC.		4,789	4,789	26
27	V	0			REGENCY REHABILITATION SERVICES, INC.				27
28	V	39	THERAPY SALARY & BENEFITS		REGENCY REHABILITATION SERVICES, INC.		33,737	33,737	28
29	V								29
30	V								30
31	V	39	PHYSICAL THERAPY	32,865	REGENCY REHABILITATION SERVICES, INC.			(32,865)	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 32,865			$ 76,975	$ * 44,110	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number REGENCY HEALTHCARE & REHABILITATION CENTRE, INC. # 0022418 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number REGENCY HEALTHCARE & REHABILITATION CENTRE, INC. # 0022418 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number REGENCY HEALTHCARE & REHABILITATION CENTRE, INC. # 0022418 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number REGENCY HEALTHCARE & REHABILITATION CENTRE, INC. # 0022418 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number REGENCY HEALTHCARE & REHABILITATION CENTRE, INC. # 0022418 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number REGENCY HEALTHCARE & REHABILITATION CENTRE, INC. # 0022418 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number REGENCY HEALTHCARE & REHABILI # 0022418 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	KENNETH NEIMAN	PRESIDENT	ADMIN	33.34%	NONE	10	25.00%	MGT FEE	$ 100,000	17-7	1
2	BENJAMIN ROGOW	VICE PRESIDENT	ADMIN	33.33%	NONE	47	78.33%	MGT FEE	125,333	17-7	2
3	LOTHAR KAHN	SECRETARY	ADMIN	33.33%	NONE	15	37.50%	MGT FEE	114,286	17-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 339,619		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees) FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number REGENCY HEALTHCARE & REHABILITATION CE # 0022418 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number (
Fax Number (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1										1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number REGENCY HEALTHCARE & REHABILITATION CE # 0022418 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: KNR ENTERPRISES
Street Address: 6625 N MILWAKEE
City / State / Zip Code: NILES, IL 60714
Phone Number: ((847) 647 - 1166
Fax Number: ((847) 588 - 1330

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	SQUARE FOOTAGE	6,654	4	$ 12,519	$	616	$ 1,159	1
2	6	REPAIRS AND MAINT.	SQUARE FOOTAGE	6,654	4	11,596		616	1,073	2
3	19	PROFESSIONAL FEES	SQUARE FOOTAGE	6,654	4	1,900		616	176	3
4	20	DUES AND SUBS.	SQUARE FOOTAGE	6,654	4	357		616	33	4
5	21	CLERICAL	SQUARE FOOTAGE	6,654	4	775		616	72	5
6	26	INSURANCE	SQUARE FOOTAGE	6,654	4	3,563		616	330	6
7	30	DEPRECIATION	SQUARE FOOTAGE	6,654	4	35,541		616	3,290	7
8	32	INTEREST EXPENSE	SQUARE FOOTAGE	6,654	4	52,915		616	4,899	8
9	33	REAL ESTATE TAXES	SQUARE FOOTAGE	6,654	4	50,342		616	4,660	9
10	33	R. ESTATE TAX-PROTEST FEE	SQUARE FOOTAGE	6,654	4			616		10
11										11
12										12
13										13
14										14
15	30	DEPRECIATION	DIRECT ALLOCATION	6,654	4	6,637			880	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 176,145	$		$ 16,572	25

Facility Name & ID Number REGENCY HEALTHCARE & REHABILITATION CE # 0022418 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: REGENCY MANAGEMENT CORP
Street Address: 6021 N. LAWNDALE
City / State / Zip Code: CHICAGO IL 60659
Phone Number: (847) 647 - 1116
Fax Number: (847) 588 - 1330

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	MNGMNT. FEE INC.	532,492	2	$ 3,765	$	472,492	$ 3,341	1
2	20	DUES, SUBSCRIPTIONS	MNGMNT. FEE INC.	532,492	2	50		472,492	44	2
3	21	CLERICAL AND GENERAL	MNGMNT. FEE INC.	532,492	2	284		472,492	252	3
4										4
5										5
6										6
7										7
8	17	ADMINISTRATIVE	AVG. HOURS-ROGOW	60	3	160,000	160,000	47	125,333	8
9	27	EMPLOYEE BENEFITS	AVG. HOURS-ROGOW	60	3	7,154		47	5,604	9
10										10
11	17	ADMINISTRATIVE	AVG. HOURS-KAHN	21	3	160,000	160,000	15	114,286	11
12	27	EMPLOYEE BENEFITS	AVG. HOURS-KAHN	21	3	7,154		15	5,110	12
13										13
14	17	ADMINISTRATIVE	AVG. HOURS-NEIMAN	16	3	160,000	160,000	10	100,000	14
15	27	EMPLOYEE BENEFITS	AVG. HOURS-NEIMAN	16	3	7,154		10	4,471	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 505,561	$ 480,000		$ 358,441	25

Facility Name & ID Number REGENCY HEALTHCARE & REHABILITATION CE # 0022418 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: REGENCY REHAB SERVICES
Street Address: 6625 N MILWAKEE
City / State / Zip Code: NILES, IL 60714
Phone Number: (847) 647 - 1116
Fax Number: (847) 588 - 1330

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	THERAPY INCOME	51,457	3	$ 1,865	$	32,865	$ 1,191	1
2	6	REPAIRS AND MAINT.	THERAPY INCOME	51,457	3	3,272		32,865	2,090	2
3	10-a	THERAPY CONSULTANTS	THERAPY INCOME	51,457	3	1,997		32,865	1,275	3
4	14	PROGRAM TRANSPORTATIO	THERAPY INCOME	51,457	3	529		32,865	338	4
5	19	PROFESSIONAL FEES	THERAPY INCOME	51,457	3	3,361		32,865	2,147	5
6	20	DUES AND SUBS.	THERAPY INCOME	51,457	3	872		32,865	557	6
7	21	CLERICAL	THERAPY INCOME	51,457	3	325		32,865	208	7
8	24	SEMINARS & EDUCATION	THERAPY INCOME	51,457	3	50		32,865	32	8
9	26	INSURANCE	THERAPY INCOME	51,457	3	12,972		32,865	8,285	9
10	30	DEPRECIATION	THERAPY INCOME	51,457	3	7,137		32,865	4,558	10
11	32	INTEREST EXPENSE	THERAPY INCOME	51,457	3	27,819		32,865	17,768	11
12	33	REAL ESTATE TAXES	THERAPY INCOME	51,457	3	7,498		32,865	4,789	12
13										13
14	39	THERAPY SALARY & BENEFI	THERAPY INCOME	51,457	3	52,822		32,865	33,737	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 120,519	$		$ 76,975	25

Facility Name & ID Number REGENCY HEALTHCARE & REHABILITATION CE # 0022418 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number REGENCY HEALTHCARE & REHABILITATION CE # 0022418 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number REGENCY HEALTHCARE & REHABILITATION CE # 0022418 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number REGENCY HEALTHCARE & REHABILITATION CE # 0022418 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number REGENCY HEALTHCARE & REHABILITATION CE # 0022418 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number REGENCY HEALTHCARE & REHABILITATION CE # 0022418 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number REGENCY HEALTHCARE & REHABILIT # 0022418 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	American National Bank		X	Line of Credit		01/01/00	$ 1,090,000	$ 960,000	01/01/01	Prime	$ 99,099	1
2	Northern Life Insurance		X	Mortgage	$64,500.00	3/01/95	6,000,000	4,680,645	3/01/10	10.0000	481,595	2
3	Regency Venture		X	Second Mortgage	$19,542.00	05/30/81	2,405,912	1,015,391	05/1/06	7.7300	87,671	3
4												4
5												5
	Working Capital											
6	Regency At-Home Care	X		Working Capital	None			80,195	Demand	IRS Rate	6,562	6
7												7
8												8
9	TOTAL Facility Related				$84,042.00		$ 9,495,912	$ 6,736,231			$ 674,927	9
	B. Non-Facility Related*											
10	Supplemental Schedule										(59,935)	10
11												11
12	Regency At-Home Care			Non-Allowed							(6,562)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (66,497)	14
15	TOTALS (line 9+line14)						$ 9,495,912	$ 6,736,231			$ 608,430	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number REGENCY HEALTHCARE & REHABILITAT # 0022418 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	Interest Income										(64,834)	1
2	Alloc-KNR Partnership	X									4,899	2
3	Alloc -Regency Rehab Services	X									17,768	3
4	Non-Allow -Regency Rehab										(17,768)	4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$ (59,935)	21

Facility Name & ID Number REGENCY HEALTHCARE & REHABILITATION CENTRE, INC. # 0022418 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	400,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	395,992	2
3. Under or (over) accrual (line 2 minus line 1).	$	(4,008)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	400,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$	5,244	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ 732 For 19 94 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	$	401,236	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	351,240	8
	1996	346,966	9
	1997	357,759	10
	1998	381,397	11
	1999	386,543	12

2000 Accrual = 1999 R/E Tax of 386,543 * 1.035 and Rounded

Line 2 includes an Allocation from KNR Enterprises of $4660 and from Regengy Rehab Services of $4789

1994 Refund not offset since it applies to year that was not used to set a R/E Tax Rate

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number REGENCY HEALTHCARE & REHABILITATION CENTRE, INC. # 0022418 Report Period Beginning: 01/01/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 89,591 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories FIVE

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

REGENCY AT HOME HEALTH SERVICES, LTD - HOME HEALTH AGENCY - SEPARATE BUILDING
REGENCY AT HOME CARE SERVICE, LTD. HOME HEALTH AND ADULT DAY CARE AGENCY - SEPARATE BUILDING
REGENCY REHABILITATION SERVICE. LTD - REHABILITATION COMPANY - SEPARATE BUILDING

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITY		4/30/1981	$ 450,000	1
2					2
3	TOTALS			$ 450,000	3

Facility Name & ID Number REGENCY HEALTHCARE & REHABILITATION CENTRE, INC. # 0022418 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	300		1981		$ 3,708,375	$ 134,359	30	$ 123,613	$ (10,746)	$ 618,065	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1987	2,440		20	74	74	444	9
10	Various			1995	55,899	480	20	2,796	2,316	15,618	10
11	SPECIALTY DECOR			1996	5,600	144	20	280	136	1,283	11
12	WALL & DOOR			1996	1,200	31	20	60	29	290	12
13	CLOSET DOOR			1996	3,500	90	20	175	85	846	13
14	CLOSET DOOR			1996	8,600	221	20	430	209	2,078	14
15	EXTERIOR TO BOILER			1996	1,395	36	20	70	34	303	15
16	RAILING REPLACED			1996	1,100	28	20	55	27	257	16
17	NEW RAILING			1996	1,100	28	20	55	27	243	17
18	MAGNETIC DOOR LOCKS			1996	1,850	47	20	93	46	434	18
19	NEW DOOR			1996	625	16	20	31	15	145	19
20	HANDRAIL			1996	3,318	85	20	166	81	761	20
21	HANDRAIL			1996	3,295	84	20	165	81	770	21
22	NEW RAILING			1996	1,100	28	20	55	27	248	22
23	PAINTING DOOR CASES			1996	2,640	68	20	132	64	594	23
24	PAGE 12-2 REP TOTALS				21,414	965		1,212	247	7,590	24
25	PAGE 12-1 REP TOTALS				1,858,895	6,505		87,783	81,278	866,383	25
26											26
27											27
28											28
29											29
30	PAGE 12F TOTALS				39,721	19,701		2,098	(17,603)	2,098	30
31	PAGE 12E TOTALS				106,674	7,452		4,769	(2,683)	6,591	31
32	PAGE 12D TOTALS				444,775	12,038		22,240	10,202	45,194	32
33	PAGE 12C TOTALS				150,973	9,552		7,549	(2,003)	18,358	33
34	PAGE 12B TOTALS				130,055	3,062		6,504	3,442	20,629	34
35	PAGE 12A TOTALS				133,505	3,627		6,680	3,053	27,855	35
36	TOTAL (lines 4 thru 35)				$ 6,688,049	$ 198,647		$ 267,085	$ 68,438	$ 1,637,077	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number REGENCY HEALTHCARE & REHABILITATION CENTRE, INC. # 0022418 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	SHELVING			1996	1,800	46	20	90	44	412	9
10	PROPOSAL/ARCH.ACCENT			1996	3,437	88	20	172	84	817	10
11	WALLPAPER			1996	3,428	88	20	171	83	770	11
12	LANDSCAPING			1996		143	20		(143)		12
13	ACTIVITY REMODELING			1996	2,780	71	20	139	68	591	13
14	ACTIVITY RM REMODEL			1996	2,350	60	20	118	58	492	14
15	AIR CONDITIONER			1996	5,400	138	20	270	132	1,237	15
16	KITCHEN FLOOR REMOD			1996	2,000	51	20	100	49	425	16
17	HANDRAIL			1996	1,100	28	20	55	27	243	17
18	WALLPAPER			1996	1,070	27	20	54	27	238	18
19	PAINTING DOOR CASES			1996	5,600	144	20	280	136	1,237	19
20	MOUNTED HANDRAIL			1996	2,254	58	20	113	55	490	20
21	BACKUP GENERATOR			1996	43,950	1,127	20	2,198	1,071	9,708	21
22	ACTIVITY RM REMODEL			1996	1,850	47	20	93	46	395	22
23	REPLACED PIPES			1996	6,150	158	20	308	150	1,258	23
24	WALLPAPER			1996	2,725	70	20	136	66	669	24
25	HANDRAIL			1996	2,730	70	20	137	67	559	25
26	LIGHT FIXTURES			1996	10,095		20	505	505	1,978	26
27	BASEMENT REMODELING			1996	3,770	97	20	189	92	772	27
28	LOWER LEVEL LIGHTS			1996		321	20		(321)		28
29	KITCHEN REMODELING			1996	1,786	46	20	89	43	371	29
30	FIRE SUPPRESSION SYS			1996	2,350	60	20	118	58	492	30
31	BASEMENT DOOR			1996	1,295	33	20	65	32	287	31
32	WALLPAPER OT HALL			1997	780	20	20	39	19	156	32
33	KITCHEN CABINETS			1997	5,070	130	20	254	124	1,016	33
34	LIGHT FIXTURES			1997	15,400	395	20	770	375	2,374	34
35	HALL REMODEL			1997	4,335	111	20	217	106	868	35
36	TOTAL (lines 4 thru 35)				$ 133,505	$ 3,627		$ 6,680	$ 3,053	$ 27,855	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number REGENCY HEALTHCARE & REHABILITATION CENTRE, INC. # 0022418 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	STORAGE ROOM DOORS			1997	820	21	20	41	20	164	9
10	CLOSET DOORS			1997	5,000	128	20	250	122	1,000	10
11	OT ROOM REMODEL			1997	410	11	20	21	10	84	11
12	WALLPAPER OFFICES			1997	1,105	28	20	55	27	220	12
13	ACT & OT RM REMODEL			1997	4,859	125	20	243	118	770	13
14	KITCHEN REMODEL			1997	1,320	34	20	66	32	264	14
15	LIGHT FIX 3RD & 4TH			1997	15,000	385	20	750	365	2,938	15
16	HALIDE FIXTURES			1997	8,500	218	20	425	207	1,417	16
17	EXIT SIGNS			1997	6,120	157	20	306	149	1,148	17
18	3RD FLOOR WIRING			1997	2,000	51	20	100	49	358	18
19	BKKPG OFFICE REMODEL			1997	2,490	64	20	125	61	448	19
20	TILE FLOOR-4 HALLWAY			1997	7,460	191	20	373	182	1,337	20
21	TILE DINING RMS FLRS			1997	2,300	59	20	115	56	412	21
22	FLOURESCENT FIXTURES			1997	3,900	100	20	195	95	731	22
23	LIGHT FIX 1ST&2ND FL			1997	15,000	385	20	750	365	3,000	23
24	BLINDS ACTIVITY & AD			1997	714	18	20	36	18	138	24
25	3RD FLOORE ENTRY SYS			1997	5,191	133	20	260	127	932	25
26	BATH DOOR HINGES			1997	1,852	47	20	93	46	326	26
27	LOBBY WALLPAPER			1998	4,509	116	20	225	109	488	27
28	BAROQUE LINING			1998	848	22	20	42	20	95	28
29	GENERATOR			1998	5,500	141	20	275	134	596	29
30	REMODELING FEE			1998	2,484		20	124	124	248	30
31	PAINTING			1998	6,243		20	312	312	624	31
32	SOAP DISPENSER			1998	1,193		20	60	60	120	32
33	FIRE DAMPER REPAIR			1998	745		20	37	37	74	33
34	CLOSED CIRCUIT			1998	11,560	296	20	578	282	1,349	34
35	NURSE CALL SYSTEM			1998	12,932	332	20	647	315	1,348	35
36	TOTAL (lines 4 thru 35)				$ 130,055	$ 3,062		$ 6,504	$ 3,442	$ 20,629	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number REGENCY HEALTHCARE & REHABILITATION CENTRE, INC. # 0022418 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	LIGHTS-1ST FLOOR HAL			1998	9,750	250	20	488	238	1,098	9
10	BLINDS			1998	359		20	18	18	36	10
11	SHOWER RM LIGHTING			1998	1,500	38	20	75	37	163	11
12	LOBBY WALL FIXTURES			1998	3,081	592	20	154	(438)	321	12
13	COFFEE NOOK LIGHTS			1998	1,000	26	20	50	24	104	13
14	PERMIT FEE-LOBBY			1998	4,789		20	239	239	478	14
15	LANDSCAPING			1998	41,600	3,557	20	2,080	(1,477)	4,853	15
16	PAINT			1998	1,174		20	59	59	118	16
17	LOBBY WINDOW BLINDS			1998	548	105	20	27	(78)	56	17
18	WATER PIPE TO 1ST FL			1998	800	21	20	40	19	87	18
19	BLINDS			1998	4,417	848	20	221	(627)	571	19
20	PAINTING & DECORATIN			1998	1,125	29	20	56	27	135	20
21	LOBBY RENOVATE			1998	7,285	187	20	364	177	819	21
22	DRAPERY			1998	1,307	251	20	65	(186)	179	22
23	FREIGHT ELEV REPAIR			1998	1,300	33	20	65	32	190	23
24	HALLWAY LOCK			1998	1,378	35	20	69	34	161	24
25	LAWN SPRINKLERS			1998	5,500	470	20	275	(195)	688	25
26	PATIO LIGHTING			1998	14,500	1,240	20	725	(515)	1,692	26
27	ELECTRICAL FEEDERS			1998	4,112	105	20	206	101	515	27
28	RESIDENT ROOM LIGHTS			1998	3,530	91	20	177	86	369	28
29	BOILER & LNDRY ELECT			1998	15,700	403	20	785	382	2,159	29
30	SPRINKLER & HVAC DRA			1998	1,512	39	20	76	37	203	30
31	DRIVEWAY			1998	10,000	855	20	500	(355)	1,292	31
32	SMOKE DETECTORS			1998	920	24	20	46	22	123	32
33	FIRE DAMPERS			1998	6,603	169	20	330	161	908	33
34	FREIGHT ELEV REPAIR			1998	5,394	138	20	270	132	788	34
35	1ST FLOOR ELECTRICAL			1998	1,789	46	20	89	43	252	35
36	TOTAL (lines 4 thru 35)				$ 150,973	$ 9,552		$ 7,549	$ (2,003)	$ 18,358	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number REGENCY HEALTHCARE & REHABILITATION CENTRE, INC. # 0022418 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	IST FLOOR LOCKS			1998	5,121	131	20	256	125	725	9
10	CC TV SYSTEM			1998	4,075	104	20	204	100	425	10
11	ENTRANCE LIGHTING			1998	2,290	59	20	115	56	240	11
12	LOBBY RENOVATIO			1998	339,964	8,717	20	16,998	8,281	36,829	12
13	WALLPAPER			1999	2,219	57	20	111	54	157	13
14	DISPENSER			1999	212	5	20	11	6	20	14
15	PHONE SYSTEM			1999	10,922	280	20	546	266	637	15
16	FLOURESCENT FIXTURES			1999	4,200	108	20	210	102	333	16
17	DRAPE			1999	169	50	20	8	(42)	14	17
18	BLINDS			1999	1,377	413	20	69	(344)	121	18
19	CARPET			1999	600	180	20	30	(150)	53	19
20	NURSE CALL SYSTEM			1999	491	13	20	25	12	42	20
21	SIGN			1999	8,180	210	20	409	199	750	21
22	LOBBY RENOVATION			1999	13,351	342	20	668	326	1,280	22
23	WALL LAMPS			1999	194	50	20	10	(40)	19	23
24	DOOR-HARDWARE			1999	2,830	73	20	142	69	284	24
25	IMPERIAL BOOSTER			1999	3,297	85	20	165	80	220	25
26	LIMESTONE			1999	1,410	36	20	71	35	83	26
27	WALLPAPER			1999	249	6	20	12	6	15	27
28	BATH TUB REPAIR			1999	870	22	20	44	22	84	28
29	COMPRESSOR			1999	23,902	613	20	1,195	582	1,693	29
30	ALARM SYSTEM			1999	3,888	100	20	194	94	210	30
31	REPLACE VINYL TILE			1999	1,829	47	20	91	44	174	31
32	SIGNS			1999	1,041	27	20	52	25	74	32
33	BORDERS			1999	3,029	78	20	151	73	189	33
34	PANELS			1999	1,365	35	20	68	33	74	34
35	FLOURESCENT FIXTURE			1999	7,700	197	20	385	188	449	35
36	TOTAL (lines 4 thru 35)				$ 444,775	$ 12,038		$ 22,240	$ 10,202	$ 45,194	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number REGENCY HEALTHCARE & REHABILITATION CENTRE, INC. # 0022418 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	OUTLET,FIXTURE			1999	14,159	363	20	708	345	944	9
10	NATURAL GAS			1999	866	22	20	43	21	79	10
11	NATURAL GAS			1999	826	21	20	41	20	68	11
12	VALVES			1999	2,518	65	20	126	61	221	12
13	SHOWER PRESSURE VALV			1999	2,766	71	20	138	67	276	13
14	WALLPAPER			1999	2,406	62	20	120	58	200	14
15	SIGN ELECTRICAL			1999	750	19	20	38	19	60	15
16	CONST-3 & 5 FLOOR			1999	11,200	287	20	560	273	1,073	16
17	ELEVATOR			1999	834	21	20	42	21	77	17
18	PLUMBING REPAIRS			1999	1,200	31	20	60	29	120	18
19	TUBE BUNDLE			1999	1,257	32	20	63	31	126	19
20	WALL LAMPS			1999	10,342	2,689	20	517	(2,172)	1,034	20
21	FLUORESCENT FIXTURES			2000	11,750	288	20	588	300	588	21
22	WIRING			2000	1,015	21	20	43	22	43	22
23	WALLPAPER			2000	4,422	632	20	203	(429)	203	23
24	BLINDS			2000	1,751	350	20	73	(277)	73	24
25	CABLE FRAMES			2000	4,979	112	20	228	116	228	25
26	FLAME PROOF DRAPES			2000	544	109	20	23	(86)	23	26
27	BLINDS			2000	1,500	300	20	63	(237)	63	27
28	MOTOR STARTER			2000	1,024	147	20	34	(113)	34	28
29	WATER PUMP			2000	2,981	426	20	149	(277)	149	29
30	MISC ELECTRICAL			2000	7,200	23	20	60	37	60	30
31	FLUORESCENT FIXTURES			2000	13,350	328	20	668	340	668	31
32	TIME CLOCK			2000	1,185	237	20	34	(203)	34	32
33	SUMP PUMPS			2000	4,241	606	20	106	(500)	106	33
34	AIR HANDLER REPAIR			2000	658		20	33	33	33	34
35	SOAP DISPENSER			2000	950	190	20	8	(182)	8	35
36	TOTAL (lines 4 thru 35)				$ 106,674	$ 7,452		$ 4,769	$ (2,683)	$ 6,591	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number REGENCY HEALTHCARE & REHABILITATION CENTRE, INC. # 0022418 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	CABLE			2000	361	361	20	36	(325)	36	9
10	CABLE & JACKS			2000	11,148	11,148	20	836	(10,312)	836	10
11	TELEPHONE			2000	9,900	1,980	20	330	(1,650)	330	11
12	ANTENA SYSTEM			2000	15,203	3,041	20	380	(2,661)	380	12
13	FIRE ALARM SYSTEM			2000	520		20	15	15	15	13
14	SMOKE DETECTOR			2000	650		20	8	8	8	14
15	CARPET METAL			2000	234	47	20	4	(43)	4	15
16	DIALYSIS CIRCUITS			2000	3,300	18	20	41	23	41	16
17											17
18	ADJUSTMENT: REMOVE ELEC FEEDERS			1998	(4,112)	3,041	20	380	(2,661)	380	18
19	ADJUSTMENT: REDUCE LOBBY RENOVATIONS			1998	(1,800)		20	15	15	15	19
20	ADJUSTMENT: INCREASE LANDSCAPING			1998	1,800		20	8	8	8	20
21	ADJUSTMENT: ADD HEAT EXCHANGER - TUBE BUNDLE			1998	1,261	47	20	4	(43)	4	21
22	ADJUSTMENT: ADD HEAT EXCHANGER - TUBE BUNDLE			1998	1,256	18	20	41	23	41	22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 39,721	$ 19,701		$ 2,098	$ (17,603)	$ 2,098	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number REGENCY HEALTHCARE & REHABILITATION CENTRE, INC. # 0022418 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number REGENCY HEALTHCARE & REHABILITATION CENTRE, INC. # 0022418 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number REGENCY HEALTHCARE & REHABILITATION CENTRE, INC. # 0022418 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number REGENCY HEALTHCARE & REHABILITATION CENTRE, INC. # 0022418 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number REGENCY HEALTHCARE & REHABILITATION CENTRE, INC. # 0022418 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			KNR	1994	$ 118,831	$ 3,047	35	$ 3,395	$ 348	$ 18,409	4
5			REGENCY	1994	122,099	3,131		3,489	358	18,915	5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16	REGENCY BLDG - VARIOUS			1985	89,361		20	4,468	4,468	71,489	16
17	REGENCY BLDG - VARIOUS			1986	191,304		20	9,565	9,565	143,477	17
18	REGENCY BLDG - VARIOUS			1987	285,236		20	14,262	14,262	199,666	18
19	REGENCY BLDG - VARIOUS			1988	23,991		20	1,200	1,200	15,596	19
20	REGENCY BLDG - VARIOUS			1989	21,445		20	1,072	1,072	12,865	20
21	REGENCY BLDG - VARIOUS			1990	83,374		20	4,169	4,169	45,857	21
22	REGENCY BLDG - VARIOUS			1991	68,572		20	3,429	3,429	34,288	22
23	REGENCY BLDG - VARIOUS			1992	18,172		20	909	909	8,179	23
24	REGENCY BLDG - VARIOUS			1993	68,257		20	3,413	3,413	27,304	24
25	REGENCY BLDG - VARIOUS			1994	38,619		20	1,931	1,931	13,517	25
26	REGENCY BLDG - VARIOUS			1995	502,505		20	25,125	25,125	125,625	26
27	REGENCY BLDG - VARIOUS			1984	145,329		20	7,266	7,266	107,055	27
28	REGENCY BLDG - VARIOUS			1983	1,868		20	93	93	550	28
29	REGENCY BLDG - VARIOUS			1982	21,300		20	1,065	1,065	6,301	29
30	REGENCY BLDG - VARIOUS			1981	10,524		20	526	526	3,112	30
31	REGENCY BLDG - VARIOUS			1980	8,420		20	421	421	2,491	31
32	REGENCY BLDG - VARIOUS			1979	32,273		20	1,614	1,614	9,549	32
33	REGENCY REHABILITATION SERVICE DIRECT ITEMS			1995	5,621	144	20	281	137	800	33
34	REGENCY REHABILITATION SERVICE ALARM			1996	1,695	171	20	85	(86)	1,270	34
35	REGENCY REHABILITATION SERVICE ALARM			1997	99	12	20	5	(7)	68	35
36	TOTAL (lines 4 thru 35)				$ 1,858,895	$ 6,505		$ 87,783	$ 81,278	$ 866,383	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number REGENCY HEALTHCARE & REHABILITATION CENTRE, INC. # 0022418 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	REGENCY REHABILITATION SERVICE -SIGN/LANDSCAPIN			1999	1,875	48	20	94	46	142	9
10	REGENCY REHABILITATION SERVICE - CLOSED CIRCUIT S			2000	256	3	20	5	2	3	10
11	REGENCY REHABILITATION SERVICE -SPRINKLER			2000	320	4	20	6	2	4	11
12	REGENCY REHABILITATION SERVICE - DRAIN TILE			2000	733	9	20	15	6	9	12
13	REGENCY REHABILITATION SERVICE - FLOOR			2000	247	2	20	6	4	2	13
14	REGENCY REHABILITATION SERVICE- PHONE			1994	2,487	217	20	249	32	2,297	14
15	REGENCY REHABILITATION SERVICE- PHONE			1995	368	33	20	37	4	319	15
16	ALLOC FROM KNR - PHONE			1994	2,421	211	20	242	31	2,236	16
17	ALLOC FROM KNR - PHONE			1995	358	32	20	36	4	310	17
18	ALLOC FROM KNR - DIRECT ITEMS			1995	5,490	141	20	275	134	781	18
19	ALLOC FROM KNR - DIRECT ITEMS - ALARM			1996	1,657	166	20	83	(83)	1,241	19
20	ALLOC FROM KNR - DIRECT ITEMS - ALARM			1997	97	12	20	5	(7)	67	20
21	ALLOC FROM KNR-DIRECT ITEMS-SIGN/LANDSCAPING			1999	1,833	47	20	92	45	139	21
22	ALLOC FROM KNR-CLOSED CIRCUIT SYS.			2000	2,000	24	20	41	17	24	22
23	ALLOC FROM KNR- SPRINKLER			2000	314	4	20	6	2	4	23
24	ALLOC FROM KNR - DRAIN TILE			2000	716	9	20	15	6	9	24
25	ALLOC FROM KNR - FLOOR			2000	242	3	20	5	2	3	25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 21,414	$ 965		$ 1,212	$ 247	$ 7,590	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number REGENCY HEALTHCARE & REHABILITATI # 0022418 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 682,158	$ 37,961	$ 42,513	$ 4,552		$ 448,220	37
38	Current Year Purchases	69,812	19,869	3,738	(16,131)		3,738	38
39	Fully Depreciated Assets	479,634					479,634	39
40								40
41	TOTALS	$ 1,231,604	$ 57,830	$ 46,251	$ (11,579)		$ 931,592	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				$	$	$	$		$	42
43										43
44										44
45										45
46	TOTALS			$	$	$	$		$	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 8,369,653	47	
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 256,477	48	
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 313,336	49	**
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 56,859	50	
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 2,568,669	51	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	BUS	$ 44,625	$ 2,570	$ 44,625	52
53	1996 DODGE CARAVAN	36,356	3,636	14,847	53
54					54
55					55
56					56
57	TOTALS	$ 80,981	$ 6,206	$ 59,472	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

REGENCY HEALTHCARE & REHABILITATION CENTRE, INC.
0022418
RELATED COMPANY MOVABLE EQUIPMENT SCHEDULE
12/31/00

LINE 28: PRIOR YEARS

COMPANY NAME	COST	CURRENT BOOK (FED) DEPRECIATION	STRAIGHT LINE DEPRECIATION	ADJUSTMENTS	ACCUMULATED S/L DEPRECIATION
REGENCY HEALTHCARE & REHABILITATION	663,186	36,700	40,711	4,011	429,680
KNR ENTERPRISES	5,446	476	545	69	5,030
REGENCY REHABILITATION SERVICE	13,526	785	1,257	472	13,510
TOTALS	682,158	37,961	42,513	4,552	448,220

LINE 29: CURRENT YEAR

REGENCY HEALTHCARE & REHABILITATION	69,812	19,869	3,738	(16,131)	3,738
KNR ENTERPRISES					
REGENCY REHABILITATION SERVICE					
TOTALS	69,812	19,869	3,738	(16,131)	3,738

LINE 30: FULLY DEPRECIATED

REGENCY HEALTHCARE & REHABILITATION	479,634				479,634
KNR ENTERPRISES					
REGENCY REHABILITATION SERVICE					
TOTALS	479,634				479,634

TOTALS (Should Tie to Totals on Page 13)

REGENCY HEALTHCARE & REHABILITATION	1,212,632	56,569	44,449	(12,120)	913,052
KNR ENTERPRISES	5,446	476	545	69	5,030
REGENCY REHABILITATION SERVICE	13,526	785	1,257	472	13,510
TOTALS	1,231,604	57,830	46,251	(11,579)	931,592

Facility Name & ID Number REGENCY HEALTHCARE & REHABILITATION CEN # 0022418 Report Period Beginning: 01/01/00 Ending: 12/31/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO
16. Rental Amount for movable equipment: $ 18,337 Description: Copiers $17,015, Helium Tanks $487, Postage Machine $833
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number REGENCY HEALTHCARE & REHABILITATION CENTRE, INC. # 0022418 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number REGENCY HEALTHCARE & REHABILITATION CENTRE, INC. # 0022418 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 24,609	$		$ 24,609	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			21,725			21,725	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-1, 39-3	hrs	71,609		37,234			108,843	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				131,086		131,086	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): **SEE SUPPLEMENTAL SCHEDULE**					16,151	89,610		105,761	13
14	TOTAL			$ 71,609		$ 99,719	$ 220,696		$ 392,024	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SUPPLEMENTAL SCHEDULE OF MEDICAL SUPPLIES

	Special Services - Supplies (Column 6 - Other)	Amount
1	Medical Supplies	89,610
2	Complex Medical Equip	
3	Oxygen	
4	Equipment Rental	
5		
6		
7		
8		
9		
10		
		89,610

	Outside Therapies (Column 5 - Other)	Amount
1	Dialysis	16,151
2		
3		
4		
5		
6		
7		
8		
9		
10		
		16,151

Facility Name & ID Number REGENCY HEALTHCARE & REHABILITATION CEN1# 0022418 Report Period Beginning: 01/01/00 Ending: 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 46,420	$ 46,420	1
2	Cash-Patient Deposits	16,074	16,074	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,489,599	1,489,599	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	25,915	25,915	6
7	Other Prepaid Expenses	1,590	1,590	7
8	Accounts Receivable (owners or related parties)	1,178,740	1,178,740	8
9	Other(specify): See supplemental schedule	212,384	212,384	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,970,722	$ 2,970,722	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		760,000	13
14	Buildings, at Historical Cost		5,240,000	14
15	Leasehold Improvements, at Historical Cos	1,041,330	1,041,330	15
16	Equipment, at Historical Cost	1,302,741	1,302,741	16
17	Accumulated Depreciation (book methods)	(1,280,133)	(1,951,928)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See supplemental schedule	99,030	99,030	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,162,968	$ 6,491,173	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,133,690	$ 9,461,895	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,009,682	$ 1,009,682	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	24,860	24,860	28
29	Short-Term Notes Payable	1,040,195	1,040,195	29
30	Accrued Salaries Payable	197,142	197,142	30
31	Accrued Taxes Payable (excluding real estate taxes)	37,972	37,972	31
32	Accrued Real Estate Taxes(Sch.IX-B)	400,000	400,000	32
33	Accrued Interest Payable	47,112	47,112	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See supplemental schedule			36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,756,963	$ 2,756,963	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	1,335,745	5,696,037	40
41	Bonds Payable			41
42	Deferred Compensation	429,768	429,768	42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,765,513	$ 6,125,805	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,522,476	$ 8,882,768	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (388,786)	$ #REF!	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,133,690	$ #REF!	48

***(See instructions.)**

Facility Name & ID Number REGENCY HEALTHCARE & REHABILITATION CE # 0022418 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUPPLEMENTAL SCHEDULE OF OTHER ASSETS & LIABILITIES **As of** 12/31/00

OTHER CURRENT ASSETS:	Amount	Amount
Real Estate Tax Escrow	169,868	169,868
Employee Loans, Advances	3,510	3,510
Accrued interest Receivable	39,006	39,006
	212,384	212,384

OTHER CURRENT LIABILITIES:	Amount	Amount

OTHER NON CURRENT ASSETS:		
Loan costs	99,030	99,030
	99,030	99,030

OTHER NON CURRENT LIABILITIES:		

Facility Name & ID Number REGENCY HEALTHCARE & REHABILITATION CENTRE, INC. # 0022418 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (581,552)	1
2	Restatements (describe):		2
3	**Schedule attached**		3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (581,552)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,377,766	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(1,185,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 192,766	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (388,786)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number	REGENCY HEALTHCARE & REHAB #	0022418	Report Period Beginning:	01/01/00	Ending:	12/31/00

Balance per General Ledger		(581,552)
Adjustments:		
		-
		-
		-
Total adjustments		-
Balance - Beginning of Year		(581,552)
Equity(Deficit) from Page 17 Col 1		(388,786)
Related Party		
Equity(Deficit)	967913	
Income	0	
		967,913
Combined Equity - End of Year		579,127

Facility Name & ID Number REGENCY HEALTHCARE & REHABILITATIO # 0022418 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 11,070,773	1
2	Discounts and Allowances for all Levels	(596,554)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 10,474,219	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	340,328	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 340,328	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	1,250	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	205,515	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	49,905	20
21	Other Medical Services	182,176	21
22	Laundry	3,696	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22**	$ 442,542	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	64,835	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 64,835	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule	888	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 888	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 11,322,812	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,626,311	31
32	Health Care	3,588,115	32
33	General Administration	2,352,627	33
	B. Capital Expense		
34	Ownership	1,780,912	34
	C. Ancillary Expense		
35	Special Cost Centers	432,381	35
36	Provider Participation Fee	164,700	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,945,046	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,377,766	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,377,766	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No-Sch Attac If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number REGENCY HEALTHCARE & REH # 0022418 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUPPLEMENTAL SCHEDULE OF REVENUES
12/31/00

	DESCRIPTION	AMOUNT
1	Prior Year Tax Refund	732
2	Misc Income - Adj. Out on p. 5	156
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		
16		
17		
18		
19		
20		
	TOTALS	888

Facility Name & ID Number REGENCY HEALTHCARE & REHABILITATION CENT # 0022418 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,927	2,209	$ 71,558	$ 32.39	1
2	Assistant Director of Nursing	3,840	4,101	101,117	24.66	2
3	Registered Nurses	38,107	41,098	775,710	18.87	3
4	Licensed Practical Nurses	19,403	21,037	368,027	17.49	4
5	Nurse Aides & Orderlies	159,808	170,008	1,564,077	9.20	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	1,847	2,033	71,609	35.22	7
8	Rehab/Therapy Aides	8,735	9,293	85,495	9.20	8
9	Activity Director	1,770	2,028	33,901	16.72	9
10	Activity Assistants	13,227	14,341	125,895	8.78	10
11	Social Service Workers	6,832	7,816	104,917	13.42	11
12	Dietician					12
13	Food Service Supervisor	1,860	2,127	46,180	21.71	13
14	Head Cook	5,727	6,360	71,891	11.30	14
15	Cook Helpers/Assistants	34,231	36,724	253,150	6.89	15
16	Dishwashers					16
17	Maintenance Workers	4,735	5,062	82,036	16.21	17
18	Housekeepers	37,137	40,554	292,203	7.21	18
19	Laundry	14,800	15,991	98,906	6.19	19
20	Administrator	1,756	2,123	128,151	60.36	20
21	Assistant Administrator	1,974	2,206	38,265	17.35	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	15,184	16,514	286,896	17.37	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,902	2,946	61,313	20.81	31
32	Other Health Care(specify)					32
33	Other(specify) Marketing Salary	1,393	1,393	40,357	28.97	33
34	TOTAL (lines 1 - 33)	377,195	405,964	$ 4,701,654 *	$ 11.58	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	441	$ 18,078	01-3	35
36	Medical Director	Monthly	15,000	09-3	36
37	Medical Records Consultant	Monthly	4,032	10-3	37
38	Nurse Consultant	182	7,280	10-3	38
39	Pharmacist Consultant	Monthly	2,250	10-3	39
40	Physical Therapy Consultant	22	1,155	10a-3	40
41	Occupational Therapy Consultant	33	1,706	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	32	1,680	11-3	44
45	Social Service Consultant	Monthly	4,800	12-3	45
46	Other(specify) Physician	Monthly	169	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	710	$ 56,150		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	2,863	$ 113,169	10-3	50
51	Licensed Practical Nurses	983	32,768	10-3	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	3,846	$ 145,937		53

Facility Name & ID Number REGENCY HEALTHCARE & REHABILITATION CENTRE, INC. # 0022418 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUPPLEMENTAL SCHEDULE OF STAFFING AND SALARY COSTS

B. CONSULTANT SERVICES

# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
		$	$
0	0	$ 0	$ #DIV/0!

Facility Name & ID Number REGENCY HEALTHCARE & REHABILITATIC # 0022418 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Barbra Hecht	Administrator	None	$ 128,151
Carol Eaton	Asst. Administrator	None	38,265
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 166,416

B. Administrative - Other

Description	Amount
Regency Management Corp. - Management Fees	$ 472,492
TOTAL (agree to Schedule V, line 17, col. 3)	$ 472,492
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
1 Services.Com	Computer Consulting	$ 384
KBC Computer Service	Computer Consulting	2,236
Purchase Plus	Purchasing Agent	950
R. Peelo & Associates	Medicare Consultant	4,200
EXT. Care	Web Site	1,500
Stanley, Stanley & Kelly	Collection Service	5,077
Frost, Ruttenberg & Rothblatt	Accounting	55,965
Gibbons	UC Tax Rate Service	2,799
See Attached	Legal	17,400
Health Data Service	Data Processing	7,038
UHC/Accu-med	Data Processing	2,987
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 100,536

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 67,385
Unemployment Compensation Insurance	27,499
FICA Taxes	355,409
Employee Health Insurance	366,703
Employee Meals	46,116
Illinois Municipal Retirement Fund (IMRF)*	
Pension Expense	49,120
Employee Benefits	9,048
TOTAL (agree to Schedule V, line 22, col.8)	$ 921,280

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 400
Advertising: Employee Recruitment	20,244
Health Care Worker Background Check	276
(Indicate # of checks performed 23)	
Dues and Subscriptions, License and Fees	36,744
Yellow Page Advertising	55,917
Advertising and Promotion	64,062
Alloc KNR Enterprise	33
Alloc Regency Rehab Service	557
Alloc Regency Management	44
Less: Public Relations Expense	( )
Non-allowable advertising	(64,062)
Yellow page advertising	(55,917)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 58,298

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	1,554
Seminar Expense	4,271
Alloc Regency Rehab Services	32
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 5,857

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number REGENCY HEALTHCARE & REHABILITATION CEN # 0022418 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number REGENCY HEALTHCARE & REHABILITATION CENTRE, INC. # 0022418 Report Period Beginning: 01/01/00 Ending: 12/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL COUNCIL ON LTC - $11,760**

(3) Did the nursing home make political contributions or payments to a politica action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YEARS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **16,635** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions fo Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen of Public Aid during this cost report period. $ **164,700**
This amount is to be recorded on line 42 of Schedule V

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classifiec in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services fo the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. $ **46,116** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation fo residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100% ln14**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all othe times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjustec out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted ou out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of service performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.

Date: **07/17/2000**

To: **Administrator/Cost Report Preparer**

From: **Office of Health Finance**

Re: 2000 Long Term Care Cost Report and Instructions on Diskette
Information Regarding the Lotus 5.0 and Excel 97 Versions of the Cost Report

Enclosed you will find a copy of the 2000 cost report and instructions on diskette. For 1999, the majority of nursing homes used the diskette to prepare their cost report. We would appreciate it if you could complete your 2000 cost report using this diskette.

If you choose not to use the diskette, you may print the 2000 cost report form and manually complete the report. If you do not have the ability to print the cost report form and instructions, please contact our office at 217/782-1630 to request a paper copy to be mailed to you.

As is stated on page 1 of the cost report instructions, this report should cover the facility's fiscal year ending in 2000. It is due on September 30, 2000, or ninety days after the close of the facility's fiscal year, **whichever comes later**. Please refer to the instructions for the remainder of the filing requirements.

There are two 2000 cost report files on the disk you have received. One file has been created for use with Lotus 5.0 for Windows. The other file has been created for use with Excel 97. A copy of the 2000 cost report instructions has been included on the diskette also. The name of the file is Instr00. It has been created for use with Word Perfect 6.1. Please use this 2000 diskette. **Printed copies of the report from the 1999 cost report diskette or earlier diskettes will NOT be accepted.**

Each page is on a separate worksheet. The file has been sealed. The cells where data is to b entered have been unprotected. Do not change the cost report form. We must have every form the same. Any changes made to the cost report form will cause us to consider the filed cost report incomplete until the form is correctly filed. Complete page one first. The facility name, IDPH ID# and the report period dates have been linked to each page. (Be sure to enter the IDPH licensed name of the facility.) **When entering data on pages 3 and 4, do not include decimals. Please round to whole numbers. When entering the years on page 12 do not enter various or other text in columns 2 or 3.**

Print macros have been written that will print each individual page or the entire report.

WARNING: Do NOT use drag & drop, cut or move commands. These commands may ruin the file and/or formulas. Then you will have to close the file and start from the last time you saved it.

As you know, save your work frequently to prevent losses of large amounts of information.

The cost report must be printed on 8 ½ by 14 size white paper with an 8 ½ by 14 image on the paper. To ensure an 8 ½ by 14 size image, check the paper size in the Printer Setup. When printing the cost report, be sure the "Selected Range" is checked. If "Current Worksheet" or "A Worksheets" are selected, the printed report will be smaller than it should be. These three selections appear in the Print dialog box. **Please do not reduce the image to 8 ½ by 11. We cannot accept a report with an 8 ½ by 11 image.** After printing the cost report, please review the copy for accuracy and completeness before mailing it to The Office of Health Finance. **Please send in the completed diskette with your paper copy, (being sure to make a copy of the diskette for your records).** Also, please make sure both the completed diskette and the paper copy agree prior to sending to our office.

Notes Applicable only to Lotus users

The entire cost report is in one file named Report00.wk4. A print preview button has been added to the bottom of each page. You may want to preview each page to ensure there are no problems before you print the entire cost report. To preview a page, click this button, then click File-Preview as normal. Also, macros have been written that will allow you to change the column width or row height of a cell or range of cells. **Only use these commands on the extra pages (24 through 33).** The print menu or the other macros menu will appear on the menu ba after you click the macro button. A macro that allows you to "Freeze Both Titles" has been added also. This will be helpful for data entry. **When saving the file in Lotus, please save it as a "WK4" file type instead of a "123" file type. To do this, click File-Save As, and then ensure the file type is "WK4".**

To copy worksheets that you have created into the blank pages at the end of the report, use Fi Combine. This will bring in the styles you used in your worksheet (except for the column width and the row height). This does not work if you are using Lotus 97. Extra sheets for pages 6, 8 and 12 have been included in the file. Click the macro buttons on these pages to make them available.

Notes Applicable only to Excel users

The entire cost report is in one file named Report00.xls. In an Excel 97 file that has been seale you can press the Tab key to go to the next unprotected cell. By pressing Shift-Tab, you can g to the previous unprotected cell. Extra sheets for pages 6, 8 and 12 have been included in the file. Click Format-Sheet-Unhide to see the sheets available. Also there are some blank unprotected sheets after "Page 23".

If you have any questions concerning the diskette, please call Randy Hulskotter at (217) 782-1630.

RH/cw